		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0031393

Facility Name: SKOKIE MEADOWS N CENTER #2

Address: 4600 GOLF ROAD (Number) SKOKIE (City) 60076 (Zip Code)

County: COOK

Telephone Number: (847) 679-1157 **Fax #** (847) 329-8633

IDPA ID Number: 36-3481217

Date of Initial License for Current Owners: 12/01/86

Type of Ownership:

[ ] VOLUNTARY,NON-PROFIT	[X] PROPRIETARY	[ ] GOVERNMENTAL
[ ] Charitable Corp.	[ ] Individual	[ ] State
[ ] Trust	[ ] Partnership	[ ] County
IRS Exemption Code ____	[ ] Corporation	[ ] Other ____
	[X] "Sub-S" Corp.	
	[ ] Limited Liability Co.	
	[ ] Trust	
	[ ] Other ____	

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) JACOB GRAFF
(Title) SECRETARY

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	111	Intermediate (ICF)	111	40,515	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	111	TOTALS	111	40,515	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	22,811	1,075	15,655	39,541	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,811	1,075	15,655	39,541	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.60%

D. How many bed-hold days during this year were paid by Public Aid?
150 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 12/01/86

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 12/01/86 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	136,362	12,482	7,468	156,312		156,312		156,312			1
2	Food Purchase		139,058		139,058	(9,946)	129,112		129,112			2
3	Housekeeping	159,441	14,186		173,627		173,627		173,627			3
4	Laundry	63,412	10,308		73,720		73,720		73,720			4
5	Heat and Other Utilities			65,527	65,527		65,527		65,527			5
6	Maintenance		10,439	24,721	35,160		35,160	415	35,575			6
7	Other (specify):* Scavenger,Security			10,985	10,985		10,985		10,985			7
8	TOTAL General Services	359,215	186,473	108,701	654,389	(9,946)	644,443	415	644,858			8
	B. Health Care and Programs											
9	Medical Director			1,200	1,200		1,200		1,200			9
10	Nursing and Medical Records	893,639	161,469	54,520	1,109,628		1,109,628		1,109,628			10
10a	Therapy											10a
11	Activities	72,383	5,239		77,622		77,622		77,622			11
12	Social Services	130,520		4,118	134,638		134,638		134,638			12
13	Nurse Aide Training											13
14	Program Transportation			622	622		622		622			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,096,542	166,708	60,460	1,323,710		1,323,710		1,323,710			16
	C. General Administration											
17	Administrative	51,486		285,912	337,398		337,398	(263,412)	73,986			17
18	Directors Fees											18
19	Professional Services			37,147	37,147		37,147	1,752	38,899			19
20	Dues, Fees, Subscriptions & Promotions			14,421	14,421		14,421	(6,042)	8,379			20
21	Clerical & General Office Expenses	22,831	6,423	283,408	312,662		312,662	(179,657)	133,005			21
22	Employee Benefits & Payroll Taxes			299,560	299,560	9,946	309,506		309,506			22
23	Inservice Training & Education			1,313	1,313		1,313		1,313			23
24	Travel and Seminar			4,385	4,385		4,385	(4,385)				24
25	Other Admin. Staff Transportation			12,036	12,036		12,036	(6,050)	5,986			25
26	Insurance-Prop.Liab.Malpractice			58,682	58,682		58,682		58,682			26
27	Other (specify):*							12,857	12,857			27
28	TOTAL General Administration	74,317	6,423	996,864	1,077,604	9,946	1,087,550	(444,937)	642,613			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,530,074	359,604	1,166,025	3,055,703		3,055,703	(444,522)	2,611,181			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 #0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			9,005	9,005		9,005	92,343	101,348			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			42,753	42,753		42,753	480,174	522,927			32
33	Real Estate Taxes			196,000	196,000		196,000		196,000			33
34	Rent-Facility & Grounds			528,748	528,748		528,748	(528,748)				34
35	Rent-Equipment & Vehicles			18,880	18,880		18,880	3,012	21,892			35
36	Other (specify):*											36
37	TOTAL Ownership			795,386	795,386		795,386	46,781	842,167			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			60,773	60,773		60,773		60,773			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers			60,773	60,773		60,773		60,773			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,530,074	359,604	2,022,184	3,911,862		3,911,862	(397,741)	3,514,121			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(7,012)	30		9
10	Interest and Other Investment Income	(139)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest	(1,485)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(3,025)	25		16
17	Non-Care Related Fees		20		17
18	Fines and Penalties		21		18
19	Entertainment		20		19
20	Contributions	(1,932)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(4,110)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(8,141)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (25,844)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(371,897)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (371,897)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (397,741)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SKOKIE MEADOWS N CENTER #2

ID# 0031393

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 415	6	1
2	NON ALOWABLE TRAVEL	(4,385)	24	2
3	NON ALOWABLE TRANSPORTATION	(3,025)	25	3
4	BANK CHARGES	(1,146)	21	4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,141)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	415	0	0	0	0	0	0	0	0	0	0	415	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	415	0	0	0	0	0	0	0	0	0	0	415	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(263,412)	0	0	0	0	0	0	0	0	0	(263,412)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	1,752	0	0	0	0	0	0	0	0	0	1,752	19
20	Fees, Subscriptions & Promotions	(6,042)	0	0	0	0	0	0	0	0	0	0	(6,042)	20
21	Clerical & General Office Expenses	(1,146)	(178,511)	0	0	0	0	0	0	0	0	0	(179,657)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(4,385)	0	0	0	0	0	0	0	0	0	0	(4,385)	24
25	Other Admin. Staff Transportation	(6,050)	0	0	0	0	0	0	0	0	0	0	(6,050)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	12,857	0	0	0	0	0	0	0	0	0	12,857	27
28	**TOTAL General Administration**	(17,623)	(427,314)	0	0	0	0	0	0	0	0	0	(444,937)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(17,208)	(427,314)	0	0	0	0	0	0	0	0	0	(444,522)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(7,012)	0	99,355	0	0	0	0	0	0	0	0	92,343	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,624)	0	481,798	0	0	0	0	0	0	0	0	480,174	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(528,748)	0	0	0	0	0	0	0	0	(528,748)	34
35	Rent-Equipment & Vehicles	0	3,012	0	0	0	0	0	0	0	0	0	3,012	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(8,636)	3,012	52,405	0	0	0	0	0	0	0	0	46,781	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(25,844)	(424,302)	52,405	0	0	0	0	0	0	0	0	(397,741)	45

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JACOB GRAFF	100	SKOKIE MEADOWS I	SKOKIE	PREMIER	SKOKIE	MANAGEMENT
		MOMENCE MEADOWS	MOMENCE	MANAGEMENT		BOOKKEEPING
		SHELDON MEADOWS	SHELDON			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	MANAGEMENT FEE	$ 285,912	PREMIER MANAGEMENT	100.00%	$	$ (285,912)	1
2	V	21	OUTSIDE CLERICAL	247,000	PREMIER MANAGEMENT	100.00%		(247,000)	2
3	V	21	OUTSIDE SERVICES	24,000	PREMIER MANAGEMENT	100.00%		(24,000)	3
4	V	17	OFFICER SALARY		PREMIER MANAGEMENT	100.00%	22,500	22,500	4
5	V	19	PROFESSIONAL FEES		PREMIER MANAGEMENT	100.00%	1,752	1,752	5
6	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT	100.00%	12,255	12,255	6
7	V	21	CLERICAL SALARIES		PREMIER MANAGEMENT	100.00%	27,314	27,314	7
8	V	21	CLERICAL		PREMIER MANAGEMENT	100.00%	52,920	52,920	8
9	V	27	PAYROLL TAXES/HEALTH IN		PREMIER MANAGEMENT	100.00%	12,857	12,857	9
10	V	35	OFFICE RENTAL		PREMIER MANAGEMENT	100.00%	3,012	3,012	10
11	V								11
12	V								12
13	V								13
14	Total			$ 556,912			$ 132,610	$ * (424,302)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	RENT	$ 528,748	M O SKOKIE MEADOWS	100.00%	$	$ (528,748)	15
16	V	30	DEPRECIATION				99,355	99,355	16
17	V	32	INTEREST				481,798	481,798	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 528,748			$ 581,153	$ * 52,405	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACOB GRAFF	PRESIDENT	Administrative,	100.00	Momence-$25,287	7	14.00	Salary	$ 22,500	17-7	1
2			Banking, Finance		Skokie 1-$22,475						2
3					Sheldon-$6109						3
4					Cal.Homes-$83629						4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 22,500		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: PREMIER MANAGEMENT
Street Address: 9933 N. LAWLER
City / State / Zip Code: SKOKIE, IL 60077
Phone Number: (847) 679-7733
Fax Number: (847) 679-7736

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	OFFICER SALARY	PER RESIDENT DAY	282,159	5	$ 160,000	$	39,678	$ 22,500	1
2	19	PROFESSIONAL FEES	PER RESIDENT DAY	282,159	5	12,460		39,678	1,752	2
3	21	CLERICAL SALARIES	DIRECT	10	4	40,850	40,850	3	12,255	3
4	21	CLERICAL SALARIES	DIRECT	4	3	109,255	109,255	1	27,314	4
5	21	CLERICAL	PER RESIDENT DAY	282,159	1	376,325	294,161	39,678	52,920	5
6	27	PAYROLL TAXES/HEALTH IN	PER RESIDENT DAY	282,159	5	91,429		39,678	12,857	6
7	35	OFFICE RENTAL	PER RESIDENT DAY	282,159	5	21,420		39,678	3,012	7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 811,739	$ 444,266		$ 132,610	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: M O SKOKIE MEADOWS NURSING
Street Address: 9615 N KNOX
City / State / Zip Code: SKOKIE,IL 60076
Phone Number: (847)679-7733
Fax Number: (847)679-7734

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	30	DEPRECIATION	DIRECT	1	1	$ 99,355	$	1	$ 99,355	1
2	32	INTEREST	DIRECT	1	1	481,798		1	481,798	2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 581,153	$		$ 581,153	25

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2												2
3	CAMBRIDGE		X	MORTGAGE	$44,062.00	8/16/01	6,822,050	6,764,215	8/16/36	0.0710	481,798	3
4												4
5												5
	Working Capital											
6	1ST EQUITY		X	WORKING CAPITAL	INT ONLY			651,742	REVOLV		41,268	6
7												7
8												8
9	TOTAL Facility Related				$44,062.00		$ 6,822,050	$ 7,415,957			$ 523,066	9
	B. Non-Facility Related*											
10	TREASURY STOCK										1,485	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 1,485	14
15	TOTALS (line 9+line14)						$ 6,822,050	$ 7,415,957			$ 524,551	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 174,620	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 185,310	2
3. Under or (over) accrual (line 2 minus line 1).		$ 10,690	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 185,310	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 196,000	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	155,035	8
	1998	168,044	9
	1999	169,802	10
	2000	174,619	11
	2001	185,310	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SKOKIE MEADOWS N CENTER #2 COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0031393

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	10-10-304-007-0000 VOL 110	NURSING HOME	$ 30,882.11	$ 30,882.11
2.	10-10-304-008-0000 VOL 110	NURSING HOME	$ 30,885.51	$ 30,885.51
3.	10-10-304-009-0000 VOL 110	NURSING HOME	$ 30,885.51	$ 30,885.51
4.	10-10-304-010-0000 VOL 110	NURSING HOME	$ 30,885.51	$ 30,885.51
5.	10-10-304-011-0000 VOL 110	NURSING HOME	$ 30,885.51	$ 30,885.51
6.	10-10-304-012-0000 VOL 110	NURSING HOME	$ 30,885.51	$ 30,885.51
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 185,309.66	$ 185,309.66

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services' ____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME			$ 341,425	1
2					2
3	TOTALS			$ 341,425	3

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	111		1990		$ 1,934,075	$ 61,399	31.5	$ 61,399	$	$ 759,851	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	IMPROVEMENTS			1987	1,200	38	15	40	2	1,200	9
10	IMPROVEMENTS			1987	1,353	43	20	67	24	1,034	10
11	IMPROVEMENTS			1987	2,329	74	10		(74)	2,329	11
12	IMPROVEMENTS			1989	6,500	206	31.5	206		2,823	12
13	IMPROVEMENTS			1990	159,219	5,055	31.5	5,055		61,626	13
14	IMPROVEMENTS			1991	1,680	53	31.5	53		640	14
15	IMPROVEMENTS			1993	6,920	177	39	177		1,671	15
16	IMPROVEMENTS			1994	21,365	548	39	548		4,533	16
17	ELECTRICAL			1996	3,351	86	39	86		591	17
18	NURSE STATION			1996	18,097	464	39	464		3,191	18
19	RAILS			1996	1,458	37	39	37		255	19
20	NEW CEILING			1996	14,883	382	39	382		2,625	20
21	WINDOW			1996	600	15	39	15		103	21
22	SHOWER ROOM VENTILATION			1996	575	15	39	15		103	22
23	NEW FLOORS			1996	15,709	403	39	403		2,771	23
24	ROOF			1996	23,100	592	39	592		3,626	24
25	PARKING LOT			1997	14,500	967	15	967		5,358	25
26	NEW STAIRCASE			1997	3,600	92	39	92		472	26
27	HOT WATER HEATER			1998	5,557	142	39	142		693	27
28	GREASE TRAP			1998	1,967	51	39	51		236	28
29	AWNINGS			1998	3,381	87	39	87		402	29
30	REPAIRS, PATCH, PAINT CEILING			1998	8,970	229	39	229		1,060	30
31	PAINTING, WALLCOVERING, BORDER PAPER			1999	25,619	657	39	657		2,327	31
32	TILING, HAND RAILS, PAINTING, WALL LIGHTS			1999	105,477	2,705	39	2,705		9,580	32
33	WALLCOVERINGS			1999	2,492	64	39	64		227	33
34	DOORS			1999	2,115	54	39	54		191	34
35	FAUCETS			1999	1,208	31	39	31		110	35
36	WALLCOVERINGS			1999	3,016	77	39	77		273	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	PAINTING	1999	$ 1,422	$ 36	39	$ 36	$	$ 128	37
38	SIGNS	1999	1,327	34	39	34		120	38
39	WALLCOVERINGS, CHAIR RAILS, KICK PLATES	1999	19,179	492	39	492		1,742	39
40	PAINTING, WALLCOVERINGS, CHAIR RAILS	1999	15,420	395	39	395		1,399	40
41	CUTOM CABINETRY	1999	12,838	329	39	329		1,165	41
42	NEW SHED	1999	1,093	28	39	28		99	42
43	KICK PLATE, WALL BUMPER	1999	9,653	248	39	248		878	43
44	LIGHT FIXTURES	1999	380	10	39	10		35	44
45	WINDOWS	1999	51,312	1,316	39	1,316		4,661	45
46	WINDOW WELLS & WATERPROOFING	1999	4,560	117	39	117		414	46
47	LANDSCAPING	1999	38,175	2,545	15	2,545		9,014	47
48	WALLPAPERING	1999	922	24	39	24		85	48
49	SIGNS	1999	2,166	55	39	55		195	49
50	PAINTING & HANDRAILS	1999	2,262	58	39	58		205	50
51	REBUILD WALL & INSTALL WINDOWS	1999	1,409	36	39	36		128	51
52	WATERPROOFING	1999	3,220	83	39	83		294	52
53	NEW VENT FOR DRYER	1999	4,271	109	39	109		386	53
54	GENERATOR	2000	3,900	142	27.5	142		355	54
55	HOT WATER BOILER	2000	3,335	121	27.5	121		303	55
56	FIRE/SMOKE DAMPERS	2000	12,049	438	27.5	438		1,095	56
57	PVC BUMPERS,PAINTING	2000	5,337	933	7	933		2,507	57
58	ROOF	2001	8,860	322	27.5	322		497	58
59	AWNING	2001	9,135	332	27.5	332		512	59
60	CONCRETE	2001	4,242	283	15	283		436	60
61	PAVING PARKING LOT	2002	13,500	450	15	450		450	61
62	ROOF	2002	66,100	1,302	27.5	1,302		1,302	62
63	TILING IN 4 SHOWER ROOMS	2002	23,400	461	27.5	461		461	63
64	TUCKPOINTING	2002	9,360	184	27.5	184		184	64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,719,143	$ 85,626		$ 85,578	$ (48)	$ 898,951	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 165,286	$ 18,385	$ 15,276	$ (3,109)	10 YRS	$ 86,852	71
72	Current Year Purchases	9,884	4,349	494	(3,855)	10 YRS	494	72
73	Fully Depreciated Assets	279,462					279,462	73
74								74
75	TOTALS	$ 454,632	$ 22,734	$ 15,770	$ (6,964)		$ 366,808	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	MAINT,AND,ACTIV.	1990 DODGE VAN	1990	$ 20,012	$	$	$		$ 20,012	76
77										77
78										78
79										79
80	TOTALS			$ 20,012	$	$	$		$ 20,012	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,535,212	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 108,360	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 101,348	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (7,012)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,285,771	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 4,133 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	DON	1998 DODGE INTREPID	$ 451.00	$ 5,418	17
18	ADMINISTRATOR	2001 DODGE CARAVAN	601.00	6,647	18
19	ADMINISTRATOR	2001 JAGUAR		2,682	19
20					20
21	TOTAL		$ 1,052.00	$ 14,747	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 **#** 0031393 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$	1
2	Cash-Patient Deposits	2,659		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	858,818		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	39,517		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 900,994	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	134,597		15
16	Equipment, at Historical Cost	34,026		16
17	Accumulated Depreciation (book methods)	(30,351)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): SHAREHOLDERS LOANS	3,609,055		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,747,327	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,648,321	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 310,351	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	4,369,502		29
30	Accrued Salaries Payable	59,774		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	185,310		32
33	Accrued Interest Payable	3,659		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,928,596	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,928,596	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (280,275)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,648,321	$	48

***(See instructions.)**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,689,930	1
2	Restatements (describe):		2
3	SKOKIE ELIMIN. ACCT., AND LANDLORD ENTRIES	(2,212,408)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (522,478)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	492,203	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(250,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 242,203	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (280,275)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,400,140	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,400,140	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	139	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 139	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING COMMISSION	3,786	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 3,786	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,404,065	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	654,389	31
32	Health Care	1,323,710	32
33	General Administration	1,077,604	33
	B. Capital Expense		
34	Ownership	795,386	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	60,773	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,911,862	40
41	**Income before Income Taxes (line 30 minus line 40)****	492,203	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 492,203	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.** TAX RETURN INCLU M.O. SKOKIE

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	5,200	5,728	$ 171,798	$ 29.99	1
2	Assistant Director of Nursing					2
3	Registered Nurses	14,198	15,489	326,409	21.07	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	40,037	43,016	395,432	9.19	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	8,539	9,029	72,383	8.02	10
11	Social Service Workers	10,620	11,203	130,520	11.65	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	21,016	21,816	136,362	6.25	15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	20,995	21,937	159,441	7.27	18
19	Laundry	8,194	8,994	63,412	7.05	19
20	Administrator	1,492	1,696	51,486	30.36	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	2,476	2,639	22,831	8.65	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	132,767	141,547	$ 1,530,074 *	$ 10.81	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 6,720	1-3	35
36	Medical Director	O	1,200	9-3	36
37	Medical Records Consultant	N	4,128	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	0	10-3	39
40	Physical Therapy Consultant	L	0	10a-3	40
41	Occupational Therapy Consultant	Y	0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	4,118	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 16,166		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$	10-3	50
51	Licensed Practical Nurses			10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
ROBERT PINION	ADMIN		$ 51,486
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 51,486

B. Administrative - Other

Description	Amount
PREMIER MANAGEMENT - MANAGEMENT FEES	$ 285,912
TOTAL (agree to Schedule V, line 17, col. 3)	$ 285,912
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
KBKB, LTD	ACCOUNTING	$ 17,750
JOHN FITZGERALD	LEGAL	5,770
FOLEY LARDNER	LEGAL	710
PETER STERNBERG	NURSING CONSULTANT	300
RESOR FINANCIAL	FINANCIAL CONSULTANT	3,700
LARRY HOVEY	ADMIN CONSULTANT	1,500
OMNICARE OF NORHERN IL	DATA PROCESSING	750
LUCY LARIOSA	ADMIN CONSULTANT	6,667
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,147

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 19,049
Unemployment Compensation Insurance	9,099
FICA Taxes	117,260
Employee Health Insurance	122,970
Employee Meals	9,946
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	9,410
EMPLOYEE PHYSICAL EXAMS	2,229
PENSION/PROFIT SHARING PLANS	19,543
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 309,506

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,207
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	4,110
TRUST/FRANCHISE/CONTRIB/ETC	1,932
LICENSES & PERMITS	1,022
DUES & SUBSCRIPTIONS	5,150
MGMT CO ALLOCATION	
TRUST/FRANCHISE/CONTRIB/ETC	(1,932)
Less: Public Relations Expense	(0)
Non-allowable advertising	(4,110)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,379

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	4,385
Seminar Expense	
SEMINARS AND EDUCATION	0
Entertainment Expense	(4,385)
TOTAL (agree to Sch. V, line 24, col. 8)	$

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINT / DECORATING	1998	$ 22,307	3 YRS	$ 7,436	$ 7,436	$ 3,717	$	$	$	$	$	$
2	PAINT / DECORATING	2001	1,246	3 YRS			208	415	415	208			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 23,553		$ 7,436	$ 7,436	$ 3,925	$ 415	$ 415	$ 208	$	$	$

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 # 0031393 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL ON LONG TERM $ 4,545.**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **60,773**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **9,946** Has any meal income been offset against related costs? _____ Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: SKOKIE MEADOWS N CENTER #2 **#0031393** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	6,720	
	REPAIRS & MAINTENANCE		748	
			0	7,468
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		23,372	
	ELECTRICITY		31,598	
	WATER		10,557	
	CABLE TV - LOBBY		0	
			0	65,527
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		10,625	
	PAINTING & DECORATING		0	
	BUILDING REPAIRS		1,194	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		5,498	
	ELEVATOR MAINTENANCE & REPAIR		2,884	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,167	
	FIRE SERVICE		2,353	
			0	
			0	
			0	24,721
7	**OTHER**			
	SCAVENGER		8,448	
	SECURITY SERVICE		2,537	10,985
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	1,200	1,200

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2		
	LABORATORY & XRAY EXPENSE		7,230	
	PURCHASED SERVICES		43,162	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	4,128	
	PHARMACY CONSULTANT	XVIII B 39-2	0	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
			0	
			0	54,520
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	0	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	0
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	4,118	
			0	4,118
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number SKOKIE MEADOWS N CENTER #2 **#0031393** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		622	622
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	285,912	285,912
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	750	
	ADMINISTRATIVE CONSULTANTS	XIX C	6,667	
	PROFESSIONAL FEES	XIX C	29,730	
			0	37,147
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	4,110	
	EMPLOYEE WANT ADS	XIX F	2,207	
	CONTRIBUTIONS	VI 20 XIX F	0	
	DUES & SUBSCRIPTIONS	XIX F	5,150	
	LICENSES & PERMITS	XIX F	1,022	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	1,932	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	14,421
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		1,146	
	EQUIPMENT REPAIR & MAINTENANCE		0	
	OUTSIDE CLERICAL SERVICES		247,000	
	PENALTIES / OVERDRAFT CHARGES	VI 18	0	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		10,159	
	MESSENGER SERVICE		1,103	
	OUTSIDE SERVICES		24,000	283,408

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	117,260	
	UNEMPLOYMENT COMPENSATION	XIX D	9,099	
	WORKERS COMPENSATION INSURANC	XIX D	19,049	
	HOSPITALIZATION INSURANCE	XIX D	122,970	
	EMPLOYEE BENEFITS - OTHER	XIX D	9,410	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,229	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	19,543	
	CHICAGO HEAD TAX	XIX D	0	299,560
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		1,313	1,313
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	0	
	TRAVEL	XIX G	4,385	
			0	4,385
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		12,036	12,036
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		58,682	58,682
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,166,025

SKOKIE MEADOWS N CENTER #2
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	139,058
LESS SALES TAX	0
NET FOOD	139,058
TOTAL PATIENT CENSUS	39,541
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	118623
ADD # EMPLOYEE MEALS/DAY	25
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	9125

PATIENT MEALS	118623
ADD EMPLOYEE MEALS	9125
TOTAL MEALS/YEAR	127748
NET FOOD	139058
DIVIDE TOTAL MEALS/YEAR	127748
COST PER MEAL	1.09
TIME EMPLOYEE MEALS	9125
EMPLOYEE MEAL RECLASSIFICATION	9946